



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

TEXAS HEALTH DBA INJURY 1 OF DALLAS

Respondent Name

AMERICAN HOME ASSURANCE COMPANY

MFDR Tracking Number

M4-17-0562-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

October 31, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...CPT code 90837 was preauthorized, #110632XXX. Please refer to the attached documentation for further review. Your immediate reprocessing and payment is appreciated."

Amount in Dispute: \$410.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "AIG has reviewed the Medical Fee Dispute Resolution Request/Response (DWC-60). In reviewing the report, it is the carrier's position that there is an extent of injury issue for these dates of services due to an intervening injury per the attached PLN-11."

Response Submitted by: AIG

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
January 22, 2016 and February 4, 2016	90837 x 2	\$410.60	\$409.46

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the preauthorization guidelines.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
4. 28 Texas Administrative Code §133.240 sets out guidelines for medical payment denials.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 1 – Documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge
 - 1 – Preauthorization not obtained

Issue(s)

1. Does the insurance carrier's position statement address only the denial reasons presented to the requestor prior to the MDR filing date?
2. Did the requestor bill for the services that were preauthorized by the insurance carrier?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 90837 x 2 units rendered on January 22, 2016 and February 4, 2016. The insurance carrier's position summary state in pertinent part, "...it is the carrier's position that there is an extent of injury issue for these dates of services due to an intervening injury per the attached PLN-11." Review of the three EOBs submitted by the requestor finds the following:

Date of Service, January 22, 2016

EOB dated received February 18, 2016 contains the following denial reason code(s):

- 1 – Documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge

EOB dated received June 16, 2016 contains the following denial reason code(s):

- 1 – Preauthorization not obtained

Date of service February 4, 2016

EOB dated received February 24, 2016 contains the following denial reason code(s):

- 1 – Preauthorization not obtained

EOB dated received June 6, 2016 contains the following denial reason code(s):

- 1 – Preauthorization not obtained

To determine whether such an extent-of-injury or related dispute existed at the time any particular medical fee dispute was filed with the Division and whether it was related to the same service, the applicable former version of 28 Texas Administrative Code §133.240 (e)(1), (2)(C), and (g) addressed actions that the insurance carrier was required to take, during the medical bill review process, when the insurance carrier determined that the medical service was not related to the compensable injury: 31 TexReg 3544, 3558 (April 28, 2006). Those provisions, in pertinent parts, specified:

Former Texas Administrative Code §133.240 (e) (1), (2) (C), and (g): The insurance carrier shall send the explanation of benefits in the form and manner prescribed by the Division.... The explanation of benefits shall be sent to: (1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill; and (2) the injured employee when payment is denied because the health care was: ... (C) unrelated to the compensable injury, in accordance with Texas Administrative Code §124.2 of this title... (g) An insurance carrier shall have filed, or shall concurrently file, the applicable notice required by Labor Code 409.021, and §124.2 and §124.3 of this title ... if the insurance carrier reduces or denies payment for health care provided based solely on the insurance carrier's belief that: . (3) the condition for which the health care was provided was not related to the compensable injury.

The Division finds that none of the EOBs presented for review contain information/documentation to support that the insurance carrier raised the issue of extent of injury as indicated by the insurance carrier. In addition, 28 Texas Administrative Code §133.307 (d) (2) (F) states, in pertinent part, "(d) Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division. (2) Response. Upon receipt of the request, the respondent shall provide any missing information not provided by the requestor and known to the respondent. The respondent shall also provide the following information and records: (F) The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review..."

The Division finds that the defenses the carrier raised at medical fee dispute resolution are new defenses and cannot be considered in this review. The division will therefore, proceed to resolve the disputed issues by addressing the denial reasons raised by the insurance carrier during the medical bill review process.

2. 28 Texas Administrative Code §134.600 states in pertinent part, "(p) Non-emergency health care requiring preauthorization includes: (7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program..."

The requestor seeks resolution for CPT Code 90837 x 2 rendered on January 22, 2016 and February 4, 2016 denied/reduced by the insurance carrier with denial reason code "1 – Preauthorization not obtained."

The requestor submitted a copy of a preauthorization letter issued by HDI Health Direct, Inc., dated December 23, 2015 preauthorizing psychotherapy 1 x 6 weeks; units/days certified (6) with a start date of 12/23/2015 and an expiration date of 02/06/16.

Texas Administrative Code §134.600 states in pertinent part, “(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care...”

The Division finds that the disputed psychotherapy, CPT Code 90837 rendered on January 22, 2016 and February 4, 2016 were preauthorized and rendered within the preauthorized timeframes. As a result, the insurance carrier’s denial is not supported. The disputed services are therefore reviewed pursuant to the applicable rules and guidelines.

3. Texas Administrative Code §134.203 states in pertinent part, “(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32. 2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year’s conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year’s conversion factors, and shall be effective January 1st of the new calendar year...”

Procedure code 90837, rendered on January 22, 2016, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 3 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 3.054. The practice expense (PE) RVU of 0.46 multiplied by the PE GPCI of 1.009 is 0.46414. The malpractice RVU of 0.11 multiplied by the malpractice GPCI of 0.772 is 0.08492. The sum of 3.60306 is multiplied by the Division conversion factor of \$56.82 for a MAR of \$204.73.

Procedure code 90837, rendered on February 4, 2016, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 3 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 3.054. The practice expense (PE) RVU of 0.46 multiplied by the PE GPCI of 1.009 is 0.46414. The malpractice RVU of 0.11 multiplied by the malpractice GPCI of 0.772 is 0.08492. The sum of 3.60306 is multiplied by the Division conversion factor of \$56.82 for a MAR of \$204.73.

The Division finds that the requestor is entitled to a total reimbursement in the amount of \$409.46 for CPT Code 90837 rendered on January 22, 2016 and February 4, 2016.

4. Review of the submitted documentation finds that the requestor is entitled to reimbursement in the amount of \$409.46, therefore this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$409.46.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$409.46 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	November 18, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.